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THE IMPORTANCE OF MAINTAINING LONG-TERM TREATMENT SERVICES FOR THE ECONOMICALLY DEPRIVED FAMILY.

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CASE PRESENTATIONS ILLUSTRATING THE USE OF VARIOUS TYPES OF TECHNIQUES EMPHASIZE THE NEED FOR LONG-TERM TREATMENT FACILITIES FOR POVERTY-STRICKEN CHILDREN AND PARENTS. THE FORMULATED TREATMENT APPROACH ATTEMPTS TO PROVIDE AN EMOTIONALLY CORRECTIVE MILIEU FOR THE CHILD WHILE HE IS LIVING WITH HIS OWN FAMILY. IT IS CONTENDED THAT FACILITIES SHOULD BE AN INTEGRAL PART OF COMMUNITY MENTAL HEALTH CENTERS OR INDEPENDENT FACILITIES CLOSELY WORKING WITH SUCH CENTERS. THE THERAPY SESSIONS, WHETHER INDIVIDUAL, GROUP, FAMILY, OR A COMBINATION TREATMENT, SHOULD BE SUPPLEMENTED BY MEDICATION, HEALTH CARE, AND ENVIRONMENTAL MANIPULATION. TREATMENT SHOULD CONTINUE FOR ONE TO FOUR YEARS, WITH FOLLOW-UP AS NEEDED. THE PROBLEM IS PROVIDING QUALITY SERVICE TO A QUANTITY OF PEOPLE. NEW METHODS OF MENTAL HEALTH INTERVENTION ARE NEEDED. COMMUNITY MENTAL HEALTH PROGRAMS SHOULD BE DEVELOPED, WHILE TREATMENT RESOURCES ALREADY IN EXISTENCE SHOULD BE SIMULTANEOUSLY EXPANDED. THIS PAPER WAS PRESENTED AT THE 45TH ANNUAL MEETING OF THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION (CHICAGO, MARCH 20-23, 1968). (PH)

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"The Importance of Maintaining Long-Term Treatment Services for the Economically Deprived Family"

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This paper deals with the need for long term treatment facilities for poverty children and parents. Two case presentations will illustrate the use of various treatment modalities. Community Mental Health Programs have made important contributions in providing a variety of much needed services. The process of establishing new facilities has created difficult problems in maintaining and expanding existing child guidance services which offer long term treatment facilities for multi-problem families in poor neighborhoods.

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The intent of this paper is to demonstrate theoretically and clinically the need for maintaining long term treatment facilities to work with poverty children and their parents. It is our contention that such facilities should be established either as an integral part of designated Community Mental Health Centers, or as independent facilities that will work in close conjunction with these Centers. By long term treatment, we mean regularly scheduled therapy sessions lasting for a period of from one to four years, with intermittent follow-up as needed after the period of intensive treatment is ended. The treatment offered might be indivicual, group, family, or some combination of these; supplemented by medication, health care and environmental manipulation as clinically indicated.

It is our impression that relatively few clinicians would maintain that poverty families should <u>not</u> have the opportunity to be treated intensively. At the same time, we are painfully aware that Social Agencies and Mental Health Clinics have only been able to reach a small group of people. Since we would like to offer more people in the community effective treatment services, we are faced with a vital question. How can we preserve existing services so that quality does not become a victim of quantity? To put it more bluntly, how do we see to it that "service to the poor does not become poor service?" From our viewpoint, this issue has become the crucial dilemma in the mental health field.

We would like to make it clear that neither of the authors has any argument with the concept of a Community Mental Health Movement. There is an enormous need for the development of new methods of mental health intervention

which will involve people regardless of economic class or race, and which will address themselves to patterns of emotional illness that are inadvertently supported by community norms and institutions. A major problem for Casework Agencies and Out-Patient Clinics which have tried to treat emotional disorders among poverty families, has been that a large proportion of these families could not be adequately involved when approached with traditional treatment techniques. Frequently the "resistant families" were overwhelmed by environmental pressures far beyond their control. Such pressures can best be alleviated through community development and social change. The significance of integrating theories and programs directed toward social change, with clinical formulations about intra-psychic process, cannot be over-emphasized.

The community mental health approach is also constructive in its emphasis on prevention and consultation; on further developing the modalities of short term, family and group treatment; and on training large numbers of indigenous non-professional people to do specialized work with emotionally disturbed families. For all of these reasons, the decision to establish a comprehensive Community Mental Health Program is a fundamental step in the development of really effective health and welfare services in this Country.

In our enthusiasm for this promising new movement however, we seem to be under-estimating the value of many fine treatment approaches that have been developed during the last thirty years. Although these programs have not been able to involve all, or even a majority, of the poverty families referred to them for treatment, they have developed techniques for

working effectively with a rather large number of these families. In reviewing the literature we discovered that there are a large number of authors who have written cogently on the theory and techniques involved in treating families from economically deprived backgrounds.

It should be emphasized that in the Redlich and Hollingshead report (9) the diagnosis of schizophrenia is made almost eight times more frequently in the two lowest economic classes than in the two highest classes; and almost three times more frequently in the two lowest classes than in the middle-class. While there are a number of possible interpretations of this data, the frequency with which lower-class people are diagnosed as being schizophrenic, is in itself a pervasive argument for a long term investment of therapeutic effort. Long term treatment still represents the best method we have of bringing about lasting, basic changes in life-long pathological patterns of adaptation.

The close relationship between community consultation programs and the need for expanded treatment resources has been graphically illustrated during recent meetings of the Committee on Family and Children, of the Bronx Association of Community Organizations. A number of school guidance counselors who had benefitted from mental health consultation in their schools were particularly concerned by the shortage of child guidance facilities in the community. They agreed that consultation had made them better able to deal with difficult children within the school environment, and had helped them in working more effectively with teachers to handle classroom situations. However the consultations had also made them acutely aware of some children with deep-rooted emotional problems. Once having

recognized these children, they were unable to refer them for treatment because of the severe lack of facilities in the community.

For the above reasons, it would be rational public policy to develop the Community Mental Health Program while simultaneously expanding existing treatment resources. Unfortunately, it is an old and questionable tradition in American society to throw the baby out with the bath water. Anything new must immediately replace everything old. This tendency is so deeply rooted in American life that it barely needs illustration. One need only look at the development of Urban Renewal Programs in our large cities since the end of World War II. In spite of the fervent pleas and cogent arguments of such Urban planners as Jane Jacobs and Charles Abrams, our most sophisticated programs have only recently accepted the principle that we should preserve and renovate older homes and neighborhoods on a selective basis, instead of tearing down everything old in a neighborhood and replacing it with new developments. One frequent result of this precipitous haste in tearing down older neighborhoods has been the intensification of the very social problems that new housing was supposed to substantially alleviate.

The implications of this social pattern are also clear for us as mental health practitioners. We are products of a society that values both planned and unplanned obsolescence. If we accept that value and develop our programs accordingly, we betray our effectiveness to the community as consultants in good mental health practice.

The emerging Community Mental Health Centers have inadvertently become instrumental in reducing existing treatment resources because they have absorbed such a large proportion of the currently available Govermental financing. A recent article by John B. Nelson (14), Medical Director of the Thom Clinic in Boston, graphically illustrates the struggle of a well established Child Guidance Clinic to find a role for itself in relation to the Community Mental Health Centers. Dr. Nelson writes that hopefully, "We will serve as a resource for all the Community Mental Health Centers... being the specialized evaluation and treatment resource of pre-screened cases from Community Mental Health Centers." However, Dr. Nelson also notes that such a role will present serious financial problems and that, in order to survive, the Clinic will"... need to demonstrate that voluntary clinics have recognizable and desirable special purposes meeting certain needs not taken care of elsewhere..."

The absence of long term treatment facilities within Community Mental Health Centers would not in itself be a serious problem, if as Dr. Nelson suggests, the community was willing to support and expand existing facilities. Unfortunately, this is not the case. In the New York City area, existing Agencies are suffering acute stress because of severe competition with the designated Centers for funds and trained staff. The result of this process is a steadily shrinking supply of long term treatment resources for children and parents, particularly those who come from economically deprived circumstances and who cannot pay even a moderate amount toward the cost of their treatment. This is occurring simultaneously with the marked expansion in New York City of private, moderate cost

treatment facilities for middle-class patients. In our opinion, the diminishing supply of long term treatment facilities is not based on a lack of clinical needs, but on the exigencies of serving many people with a limited amount of money and with a limited number of trained professional staff.

Because of this dilemma in the field of mental health, we feel that it is a particularly appropriate time to review some techniques that have been effective in the treatment of economically deprived children and parents. Our aim is to illustrate some of the changes that can be accomplished through intensive, long term treatment. The cases that will be presented here all entail some major difficulties that we feel could only have been overcome through an investment of therapeutic time and interest lasting over a number of years.

In our work with poverty families, we have learned that the "disturbed" child who comes from an economically and emotionally deprived environment, is most frequently a child who did not receive sufficient nurturing during his early years. He usually feels rejected not only by his parents, but by the school and the community. Especially if he is a Negro or Puerto Rican child, he approaches an agency with suspicion, discouragement and hostility. His essential needs is to develop some basic trust in another human being, a process that best takes place during a long period of relationship with a stable person in a benign environment. He is likely to lack ego skills, to have an extremely poor self-image, and to see the world as a pervasively hostile and inconsistent environment.

For these reasons we have formulated a treatment approach which attempts to provide an emotionally corrective milieu for the child while he is living with his own family. Treatment sessions are directed toward helping the child express and understand his infantile feelings, his conflicts, his distrust of close relationships and his confusions. However, the development of insight is insufficient unless we also offer the child selected life experiences that will increase his sense of ego adequacy and independence. Such services as a Big Brother, a specialized camp, a Community Center Program, intervention with a school to provide a more suitable educational approach, etc., become vital ingredients in the successful rehabilitation of these children and their families.

Steve, a white, Jewish boy of 11, was referred to the Child Guidance Clinic of the Jewish Board of Guardians because of poor school achievement, lack of friends and arguments with his mother at home. Mrs. A was concerned that he would not develop into an adequate, self-supporting man. She complained that he was unwilling to do his homework or help her with household chores. He was excessively devoted to watching televion, had no peer relationships, and was obese. A medical report showed that he had an undescended testicle. In the screening interview, he complained mildly that his mother nagged him but aside from that, felt that he had no other problems.

The family consisted of Steve, his sister Anne who was 2 years older, and his mother. Mr. and Mrs. A had separated shortly after Steve's birth. Mr. A was not making any regular financial contribution to the family and Mrs. A had been receiving Department of Welfare aid since shortly after her separation. Although Mr. A had been granted visitation rights at the time of the separation, they were revoked by the Court when Steve was 8 years old, following a series of bizarre incidents between Mr. A and the children.

The developmental history was relevant in two particular respects. Mrs. A reported that she had married Mr. A unwillingly after he had raped her and made her pregnant. She also claimed to have been raped when Steve was conceived. Her hostility toward men in general, toward her son and husband in particular, was clearly revealed during the intake interviews. The childhood history showed that Steve had been somewhat delayed in his maturation at all stages of development.

Psychological testing indicated a Full I.Q. of 74 with limited potential for higher functioning. A neurological examination ruled out any gross organic condition but confirmed the likelihood of mild diffuse brain damage. The psychiatric diagnosis was "a generalized delay in ego development and physical maturation," accompanied by some neurotic fears and a serious problem in characterological development. This diagnosis was helpful in that it encouraged the therapist to be patient and to set limited goals for the treatment of this case.

The original treatment plan called for individual treatment of the child and mother with different therapists and periodic contacts with Mr. A to see whether he could be helped to play a more constructive role in the children's lives. The first year of Steve's treatment was focused on arranging for medical treatment to ensure that his testicles were in place before the advent of puberty, and on dealing with the emotional problems connected with his physical condition. The testicles were successfully brought down through a series of hormone injections. Steve revealed his feeling that he had the "littlest dinky (penis) in the whole world."

Following this period of intensive therapeutic involvement, individual treatment seemed to bog down with Steve. Although he continued to come regularly and on time for his appointments, he was depressed and passive during interviews. Exploration, support and interpretation all produced anxiety accompanied by long silences. Because of the apparent stalemate in individual treatment, we decided to offer Steve an opportunity to join an activity group. We hoped the group would help him more directly express his hostility and encourage his interest in peer relationships. We also arranged for him to have a Big Brother since we had been forced to conclude that Mr. A could not modify his pathological relationship with the children.

Steve showed great interest in the activity group and the Big Brother. The group therapist reported a gradually increasing interest in other boys and some progress in self-assertion. At home, Steve was becoming more rebellious and Mrs. A became concerned that he was getting worse. However, her treatment helped her understand and accept this as a temporary phase in the gradual development of greater self-assertion on his part. An educational evaluation confirmed that Steve had been four years behind in academic achievement and remedial education was initiated.

At the end of the second year of treatment, in spite of the considerable investment of Agency time and service, there had been insufficient symptomatic change in Steve's behavior except in the activity group. At this point, the question of continuing his treatment was raised in a clinical meeting. The conference indicated that Steve had established a maternal transference with each of the people who were seeing him individually. His passivity and obsessiveness in reporting minute details, were defenses against intense rage which he could not permit himself to feel or express toward his mother. In spite of this understanding, which turned out to be correct, all of the people involved in individual relationships with Steve, continued to feel frustrated in their efforts to help him.

Toward the end of the third year of treatment, the therapist took advantage of an opportunity to shift the transference. A routine eye examination at a local municipal hospital resulted in a recommendation for an eye operation to correct Steve's strabismus. Steve was opposed and his mother was in favor. The therapist intervened on Steve's side by insisting on a second eye examination by a specialist who was the Agency consultant. In so doing, he indicated to Steve that he was interested in him and that he did not consider Mrs. A to be all-powerful. The mother, who had made considerable progress in her treatment, agreed to let our consultant make the decision. The consultant did not recommend the operation. Steve was elated.

In treatment interviews following this, Steve became more talkative but also more provocative. He frequently expressed his utter helplessness in doing the simplest things. He seemed to be unconsciously trying to provoke the therapist either to criticise him or to treat him like a baby by doing everything for him. This was the most intense point in the "transference neurosis." Steve was presenting himself as considerably less adequate than he actually was. He was expressing both his intense anger at his parents who had belittled and infantilized him and his need to be nurtured in a dependent relationship. The therapist finally conveyed the attitude that Steve was not succeeding in provoking him by failing and being helpless. This comment was followed by two silent sessions. In the third session, Steve asked the therapist to play checkers. The therapist at first tried to interpret the resistance, but when Steve ignored the interpretation, the therapist acceded to his request. Steve promptly won the first, second and third games played. Playing at his best, the therapist was barely able to draw the fourth game. At this point, he interpreted, "You are not as stupid as you would like people to think." Steve smiled.

It is both noteworthy and typical that Steve's decision to show the therapist some of his true capabilities was presented in a non-verbal way even though he was an adolescent boy at the time. Since the therapist had accepted Steve's need to present himself as a helpless, inadequate person, Steve was now testing whether the therapist would accept his increased aggressivity and competence or whether the therapist, like his parents, would need to belittle his real capabilities. Following this, there was a rapid and dramatic change in all areas of Steve's functioning. He began to make friends, to play ball and to spend more time outside the home. His school work gradually improved. A follow-up Psychological showed a Full I.Q. of 91 with a Verbal Score of 99. Conflicts with his mother continued however and Steve asked us for help in moving away from home to a Residence for teen-age boys. We agreed that this would be beneficial to him in his struggle for greater independence. When we had concluded arrangements for him to move to the Residence, he commented that he now understood that his mother had made him feel weak by doing too much for him. "She made it so easy for me to do nothing by going to school and telling them my sad story, that I figured I should just sit back and do nothing. I was lazy. It is only now that I can fight her and do things for myself." When the therapist asked why it had taken so long for him to come to this conclusion, he said "it takes a long time for me to talk to someone."

In retrospect, the therapist felt that Steve's appraisal of the situation was quite accurate. During the first two and a half years of treatment, Steve had evidently been testing the therapist's patience and acceptance of him. Even the initial treatment intervention to ensure his masculine adequacy by obtaining medical treatment for the undescended testicle, did not entirely resolve his feelings of suspicion and distrust. It was only after he had expressed a great deal of hostility in the transference and the therapist had accepted these feelings, that he was able to develop sufficient trust to show his "true colors."

At this point, regular treatment was concluded by mutual agreement. The therapist made himself available for periodic follow-up contacts. Steve is now 20 years old, has worked since he was 17 and is currently training to do merchandising work in a large department store. He has his own apartment, is taking night courses in a high school to improve his English and Math and has dated during the past two years.

Although the individual treatment of this child had been presented in most detail here, all of the different methods of intervention used in this case played an important role in Steve's eventual improvement. Of crucial importance was the mother's treatment which helped her to release Steve for emotional growth in the direction of maleness and self-sufficiency. She also moved in the direction of developing social interests outside the home that were satisfying to her. During the course of treatment, it should be noted that the following modalities were used: individual treatment for the child and parents, group therapy for the child, remedial education, a Big Brother, referral to a social work camp, and referral to a Residential Treatment Center for adolescents. This was admittedly an expensive and lengthy course of treatment, but considerably less costly to the community than life-long support from the Department of Welfare or possible institutionalization.

The first case presented was a white, Jewish boy from an economically deprived environment. We have been able to apply similar approaches to some of the multi-problem Negro and Puerto Rican families who were originally referred to us by the New York City Youth Board, but who have more recently come from other community resources, particularly the public schools. In treating Negro and Puerto Rican families however, we have had to be aware of some additional factors. Because of the many reality problems in their lives, and the early emotional deprivation, there often is a greater tendency to project problems onto the school or community. The therapist

therefore has to be more alert in distinguishing what is culturally conditioned and what is part of the child's own intrapsychic problem. We have learned that most of these children and their parents are extremely distrustful of us in their early contacts. They seem unimpressed and unconvinced of our good intentions. Herta Riese writes (19, p. 341), "...The worst tragedy that befalls these children is the absence of an opportunity to become aware of their lovable traits. They know only of the ugly responses. Agreeing with those who reject them, they are unaware of their worth." We approach these families with full awareness of their suspicion, with patience and with a conviction that they will eventually reveal their true feelings to us if they are not pressured. We have found that once these families do develop some trust in the therapeutic relationship, their feelings of self-worth increase. At this time, they frequently become more spontaneous, more genuine, and less resistant than many guarded middle-class clients who use intellectualization and rationalization as powerful resistances toward change in treatment.

Because of the intense suspiciousness with which these families approach a treatment contact with an Agency, we have found that it is often a serious mistake to apply traditional child guidance techniques in a routine manner. Our attempts to obtain developmental history is a good example of this problem. While questioning a mother to clarify the maturational process and early relationships, it is essential that the therapist keep in mind the reasons for her distrust. Previous experiences had been with the Department of Welfare and other Governmental Agencies where she could not be sure whether such questioning was designed to help her, or to "trap her" into damaging admissions. In very large families,

the mother frequently could not remember important details because she had been so overwhelmed by a progression of births, that she could not individualize her children. Sometimes the conception or birth of a particular child was connected with events which the client felt would be unacceptable to a white, middle-class therapist. For these and other reasons, we have often had to be satisfied with a sparse history and an incompletely formulated diagnosis at the beginning stages of treatment. Our patience has usually been rewarded with considerable additional information when the client had expressed and worked through some feelings of distrust.

We have also learned not to become overly frustrated with broken appointments or lateness. On some occasions such lapses might result from reality factors, such as a sick child. Cultural attitudes toward time are also very significant. In addition, patients who have repeatedly spent interminable periods of time in hospital waiting rooms, are not inclined toward promptness when they initially become involved with a treatment Agency. More frequently however, there are psychological reasons for broken appointments. The child and parents who come to a clinic under pressure from the school see us as part of a punitive authority. The more we pressure for regular appointments, the more fearful and suspicious they become. Since most poverty families are unable to overtly verbalize their hostility, they demonstrate it through passive aggression. The therapist therefore should be prepared to accept a certain number of broken appointments and should not be unduly discouraged when they occur. The better a therapist understands the dynamics of this phenomena, the

more success he will have in establishing a constructive relationship with his lower-class patients. It should be emphasized however that in a clinic setting, the therapist's ability to accept and understand the phenomena of broken appointments, is largely dependent on the attitude of the Agency administration. Broken appointments can create statistical and financial problems for an Agency. The Agency administration must be prepared to accept such problems if there is to be a serious attempt at treating poverty families.

In general, we have observed that when a therapist feels free to discuss Negro-White feelings, the client is better able to verbalize his own anger, hurt and frustration, thereby promoting a relationship in which the therapist and patient can work together toward common goals. However, it often takes considerable time before the client is prepared to reveal these feelings. Tactfulness, sensitivity and a willingness to deal directly with the issue when it does arise, are essential attitudes for the therapist. He must therefore be willing to examine his own feelings honestly and to deal with his conscious or unconscious prejudices.

One of the more difficult issues that arises in our work with poverty families develops around the problem of dependency. It is vital that we carefully evaluate what the client is able to do for himself in order not to impair his own strengths and self-respect. In the case of an adolescent girl who was very guarded during treatment sessions, the female therapist offered to take her out for lunch in an attempt to establish a better relationship. The girl reacted to this offer with increased suspiciousness and negativism, stating that she did not want any charity. Apparently any attempt to give her things in a concrete way represented

a degrading and infantilizing act of charity to her. It was only at a much later point in treatment, when she had developed a more trusting relationship with the therapist and had begun to make progress, that she was able to accept a gift.

Our work with these patients has been very much family-oriented. Treatment of mothers was of the utmost importance. Wherever possible, we have also tried to strengthen the role of the father or of another male person in the environment. This has been especially important since Negro boys frequently develop an extremely poor image of male figures. The child often takes over society's concept that Negro men are bad, inadequate, weak, and over-sexed. In recent studies, there has been emphasis on the benefit of using more successful Negro men as Big Brothers, thereby supplying these children with a more adequate object for male identification.

In most of the poverty families we have worked with, learning difficulties play an important part in the development of pathology. Children frequently have had traumatic learning experiences not only at school, but also within the home. The ability to learn effectively and with pleasure develops first during the early mother-child relationship. It has been reported in various studies of children from poverty areas, that "...there is less interaction between the mother and child in the under-privileged household." "The object in the home, the amount of parental interest in learning and the amount of practice and encouragement that a child is given in conversation and in general learning, have been found to be significant influences on language and cognitive development, - development of interest in learning, attention span and motivation." (6)

For these reasons, children with learning difficulties frequently need contact with a benign person who can make learning a more pleasurable experience and at the same time, establish reasonable educational goals. Expectations that are not attainable are discouraging and damaging to self-esteem, but expectations that are not sufficiently challenging can equally well produce passive resistance and confirm feelings of inadequacy. In most cases, tutoring and therapy have been done by two different people, the remedial tutor and the therapist working closely together. We have found that in some situations, it has been advisable for the tutor to also do the treatment under close supervision by an experienced therapist. This approach is considered essential with families who are unable to recognize or accept that they have emotional problems, but who are quite willing to involve themselves in the less threatening service of tutoring. In these cases, the teacher-therapist recreates an early learning situation which symbolizes the crucial childhood interaction where mother-teacher are the same person. The following case illustrates some highlights of this approach.

Larry B, an 11 year old Negro boy, had been referred by the school because he was presenting learning and behavior difficulties in school. He had gotten into serious fights and had been suspended from school. His problems had started in the second grade. He also had various fears and complained about headaches.

Larry was the youngest of six children. He had three older brothers and two older sisters who were born during his mother's first marriage. Mrs. B's husband died in an accident shortly after she had conceived Larry in a casual relationship with another man. Mrs. B was estremely embarrassed about this pregnancy and did not want the child. She was depressed after the birth and was often unable to take care of him. However, her rejection of him evoked guilt and she became inconsistent in handling him. At certain times she was indulgent and at other times, she was extremely punitive. The family was also undergoing severe financial stress and Mrs. B had to take a job as a domestic.

Larry was aware that he had been born out-of-wedlock because he had a different name from his other siblings. His skin was darker than the other children and he often felt inadequate and unwanted. At the same time, he brggged that his father was still alive whereas the father of his siblings was dead.

Psychological testing revealed an I.Q. between 80 and 90. Diagnostically, Larry gave the impression of a boy with mixed neurotic and behavioral symptoms who had great difficulty in handling problems of aggression because he was terrified both of his own impulses and of fantasied reprisal. The treatment plan was to offer him a great deal of emotional nurturing and to simultaneously help him in finding safe outlets for his aggression. The therapist would act as an "auxiliary ego" and as a model for constructive identification. An attempt would be made to teach him how to organize his school work and to help him develop constructive interests outside of the family. Because Larry had related so well to his tutor in the Agency, and because of the constant flow of people moving in and out of the B home, we decided that the total treatment responsibility should be in the hands of one stable person. He was therefore assigned to the remedial educator for treatment as was his mother.*

At the beginning of treatment, the teacher-therapist reported that Larry was extremely responsive to emotional nurturing. When he was praised, his sense of self-esteem markedly improved. Criticism hurt him excessively; he would visibly withdraw and lose interest in his work. He could not express anger directly toward the teacher-therapist during the early stages of their relationship because he had to maintain his image of her as a good object. He reported that he included her in his prayers.

The teacher-therapist took an interest in many areas of Larry's life. She took him to the Zoo and other places in order to enrich his experiences. She also went with him to the doctor when his mother had not been able to take over this responsibility. She had frequent contacts with the school in order to adjust his program so as to better meet his educational needs.

His learning was motivated initially by his wish to please the teacher-therapist. He felt obligated to appease adults whose power he could never fully trust and whose good-will he could never really depend upon. Gradually he was able to speak more freely about his feelings of inadequacy and about his need to appear strong at precisely those moments when he felt most helpless. He said at one point, "I'm not letting anyone think I'm afraid." He gradually became able to talk about some of the underlying fears that he had previously denied. He began to talk about his father and about his having darker skin than his siblings. He expressed resentment in discussing his father's punitiveness, but at the same time tried to identify with some of the father's more positive features. He expressed protective feelings towards his mother. He gradually learned that he could differ with his teacher-therapist or be angry at her without being destroyed.

* The treatment of this case was handled with devotion by Miss Lux Elsner.

He also felt freer to express some negative feelings about the harsh treatment he had suffered from white people. He never included his teacher-therapist in his criticisms however, because he considered her to be "different." Whatever negative feelings he had toward her as a white person were suppressed because of his great need for her. He stated that he wanted to continue seeing her until he was in the 12th grade. Toward the end of treatment, he mentioned that he now felt different about being "Black." He said it was not such a problem to him that he was darker than his half-siblings. This change in his self-image had probably been somewhat influenced by his mother's modified attitude toward him. In her treatment, she had worked through a great many intense feelings of shame and anger related to her being Black. However, Larry's improved self-image was also influenced by a changed attitude in the community where the developing Civil Rights Movement had engendered strong feelings of pride connected with being Negro. Larry expressed an interest in African culture and geography. He periodically tested the teacher-therapist's knowledge of these subjects and was immensely pleased when she was able to talk with him about them.

He indicated some concern about the increased responsibilities of growing up. He had enjoyed earning money during vacation and on after-school jobs. He was in conflict about continuing to go to school and considered dropping out at the age of 16. However, he also realized that if he did not complete high school he could not advance vocationally. He decided to continue his schooling until graduation.

After almost four years of combined treatment and remedial tutoring, Larry had shown marked improvement in many areas of his functioning, especially academically and in social relationships. By mutual agreement, it was decided that he could now function more independently. His treatment sessions were reduced to once a month.

Mrs. B had initially been resistant to treatment for herself. She only became involved after the teacher-therapist made a home visit. This was done at a time when she had not responded to a number of letters. The teacher-therapist visited the home to inquire about Mrs. B's health and her feelings about her son's functioning. After the home visit, Mrs. B came more regularly for her appointments at the office and began to talk a great deal about her own fears of death and aggression. She discussed some of her conflicts in handling Larry and the other children. In addition to helping Mrs. B work through these feelings, the teacher-therapist helped in securing a job for her older son and in making school arrangements for the other children.

We may question how much real insight Mrs. B developed during the course of her treatment. Nonetheless, she has gained sufficient understanding of her feelings toward her children so that she has been able to modify her handling of them. Because she had been given to, she could be more giving with her family. Because she had been able to openly express her angry feelings in treatment, she no longer had to induce her children to act out these feelings for her in the community.

The fact that Larry and his mother were both treated by the same person, and that this person also arranged for all of the collateral services, was extremely important in creating some cohesiveness and stability in this chaotic family situation. Larry himself stated that his teacher-therapist had become one of the most meaningful people in his life. Larry is now 14 years old. He will still need occasional contacts in order to help him maintain his gains during the difficult period of adolescence. His mother's greater understanding of his needs will be a positive factor in his future development.

We would like to emphasize that in treatment, whether with middle or lower-class patients, there is a great need for diversity in approaches. Due to the prevalence of multiple problems, this flexibility is even more important in working with culturally and economically deprived families. Thorough clinical knowledge, including an understanding of normal development, of psychopathology, and of the individual's functioning in his social milieu, is necessary in determining the mode and goals of therapeutic intervention. This is true regardless of whether the approach is long term, short term, individual, family or group treatment; consultation, environmental manipulation, or the use of para-professional personnel. Rae-Grant, Gladwin and Bower (17) also emphasize this view: "With the change in training and practice, let us not fall into the error of so many other revolutions, of losing what is valuable in our existing practice. The sensitive and intuitive observation and understanding of the individual is, and will remain, the unique contribution of a mental health professional which no one else can provide... Only by maintaining his skill of insight and perception can the mental health professional competently counsel others and operate safely even though one step removed from the individual... Skill and examination and intervention with the individual must remain in nature an ingredient of mental health professional training. It is still the best method to study the fascinating interplay between the individual and the forces in his cultural environment."

As the previously cited cases clearly illustrate, it is possible to involve very resistant poverty families in treatment, with good results, if the clinical approach is flexible and the therapist is patient. The length of time that such treatment takes is basically determined by the degree of early emotional deprivation and/or inconsistency that the patient has experienced, and by the severity of his reality situation. Insight-oriented treatment with ego-damaged lower-class patients may not begin until the second or third year of involvement. The initial stage of treatment, which the therapist often experiences as being frustrating and unproductive, is really a period during which the patient relives his very early object relationships in the transference. A longer course of treatment is necessary for those patients so that they can work through issues of object constancy and basic trust that are genetically related to experiences during the first year of life. By offering a stable therapeutic relationship designed to alleviate the patient's unmet emotional needs, it becomes possible to correct distorted object relationships that have interfered with ego development and with functioning at all levels of psycho-sexual and social development.

The authors are also aware that this paper indirectly raises a fundamental social issue. With so many people in need of help and so few professional and financial resources available, how can we propose that long term treatment facilities should be expanded and that simultaneously Community Mental Health Centers should be established? The basis of our argument lies in the fact that neither we nor other professionals can suggest in good conscience that treatment methods be used which are inappropriate for a given case. We are fully aware of the fact that many social ills in

the community cannot be remedied by even the best treatment methods. The development of more vigorous community programs is essential for basic social change. We have recently seen how new community mental health programs, even the most effective ones, are in danger of being terminated because of inadequate financing. One cannot calculate the amount of damage done by programs which raise the hopes of poverty families and then vanish, because Governmental money that should support them is being diverted for other use.

Perhaps our dilemma would be less painful if the mental health field would boldly express a conviction that Federal funds should be used to improve social and mental health conditions, rather than for the purpose of waging war. Although an end to the Vietnam war would not in itself solve the dilemma, it would provide an unparalleled opportunity to develop effective mental health services for increasing numbers of people, regardless of economic condition, race or religion.

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